QualChoice® HEALTH INSURANCE

Product Selection & Sold Rate Form

This form must be filled out by all **Renewing Groups** and **New Groups**.
New Groups must also fill out, sign and attach the *Group Application for Coverage*.

Section I. Group/Plan Sponsor Information

Group/Plan Sponsor Name		
Effective Date/Renewal Date (MM/DD/YYYY)	Name of Broker/Agent of Record	Agency Name

Section II. Medical Enrollment Count *This section is **required** or form cannot be processed.*

IMPORTANT: For purposes of determining group size, the Patient Protection and Affordable Care Act ("PPACA") defines the number of employees as "the average number of employees employed by the company during the **preceding calendar year**." An employee is typically any person for which the company issues a W-2, regardless of full-time, part-time or seasonal status or whether or not they have medical coverage.

Number of employees on the last day of each month divided by 12 for previous year: **Average Total Number of Employees =** _____

NOTE: If you are part of a controlled group or an affiliated service group, you may be considered an applicable Large Employer as defined by PPACA and subject to Large Employer underwriting and enrollment rules. If not sure, consult with your accountant regarding your employer status.

MEDICAL ONLY - Provide current Employee Counts. *(Full-time means an active employee working at least 30 hours/week and 48 weeks/year.)*	**In State**	**Out of State**	**Total**
No. of Full-Time Employees Enrolling Include those satisfying their waiting period within 90 days after the effective date			
No. of Full-Time Employees Declining Coverage Include those satisfying their waiting period within 90 days after the effective date			
No. of Retirees eligible for coverage			
No. of COBRA or **AR State Continuation Coverage** enrollees			
Total Enrolling and Declining			
Part Time/Seasonal/Temporary Employees			
Total Number of Employees			

In the preceding calendar year, has the group had 20 or more employees, or at least 50% of group's working days? ☐ **Yes** ☐ **No**

Section III. COBRA Administration **PEPM rates reflect minimum monthly fee required by PrimePay.*

Group health plans for employers with 20 or more employees on more than 50% of the business days in the previous calendar year are subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA). Employers are required to provide qualified beneficiaries an election period during which the beneficiary can elect to continue coverage under the guidelines. We offer the services of a vendor, PrimePay, to assist you in administering COBRA. Both full-time and part-time employees are counted to determine if a plan is subject to COBRA.

NOTE: A minimum of 20 eligible subscribers is required for QualChoice to bill for COBRA Services.

As an employer, are you currently obligated by law to comply with COBRA?	☐ Yes	☐ No
Do you want to use the services of PrimePay? *If YES — please answer the following questions:*	☐ Yes	☐ No
• Are you currently contracting with PrimePay?	☐ Yes	☐ No
• If you have a minimum of 20 eligible subscribers on your plans, is QualChoice billing the group for PrimePay?	☐ Yes	☐ No
• Is QualChoice sending electronic eligibility to PrimePay? **NOTE:** *Only available for groups of 100+ eligible employees.*	☐ Yes	☐ No

Number of Eligible Employees (EEs)	20	21-29	30-39	40-59	60+
COBRA Fee Per Employee Per Month (PEPM)	$4.50	$3.25	$2.25	$2.00	$1.50

Section IV. ID Cards

If purchased, Medical and Dental ID cards are to be delivered to: ☐ Group Always ☐ Group (Initially) ☐ Individual

If purchased, Vision ID Cards are mailed to the member's address by Superior Vision *(administrator of QualChoice Vision Benefits)*.

Section V. Enrollment and Eligibility Rules. Enrollment and eligibility rules apply to all ancillary products offered through QualChoice.

Are all employees covered by workers' compensation? ☐ **Yes** ☐ **No**
If **YES**, name of the workers' compensation carrier: _____

Please check the eligibility classes of employees for medical, vision or dental coverage.

☐ **Full-Time** active employees. *Full-Time* is active employee working at least 30 hours/week and 48 weeks/year.

☐ **COBRA**

☐ **Retirees.** Only available to groups of 100+ employees.

New Hire Enrollment
For multiple waiting periods, please define employee class

Waiting Period *(Check One)*

☐ Date of Hire ☐ First of month after date of hire
☐ First of month after 30 days ☐ First of month after 60 days

Class _____

Waiting Period *(Check One)*

☐ Date of Hire ☐ First of month after date of hire
☐ First of month after 30 days ☐ First of month after 60 days

Class _____

Open Enrollment

☐ 30 days before renewal date
☐ Other (subject to underwriting approval). *Explain below.*

New Groups Only

Are you waiving the initial waiting period? ☐ **Yes** ☐ **No**

NOTE: Only applies to employees in their initial waiting period and would be effective on date of the group contract.

Effective Date For Re-Hires

- No re-hire policy. Employee must fill out waiting period as new hire.
- Effective date is first of the month following re-hire date.
  - No. of months between termination date and re-hire date. *Please fill in no. of months -or- check no. of months.*

  _____months No. of Months: ☐ 3 months ☐ 6 months
- Rehire Policy, Other _____

NOTE: *If re-hire date is greater than 6 months from termination date, employee is subject to new hire waiting period. Large groups may be subject to penalties under the employer shared responsibility mandate if certain re-hired employees are required to complete a waiting period.*

Termination Date

Termination date will be on the last day of the month of termination for employees or dependents.

Section VI. Employer Contribution

% of Employee Only: _____% *(cannot be less than 50%)* **or** $_____PEPM

% of Dependents: _____%

Section VII. Medical Plan Selection

Depending on the type of health plan your group falls under, complete and submit **one** of the following attachments with your form.

Attachment 1: Non-Grandfathered Small Group (2-50 eligible employees) Plan - *ACA Metallic Plans*

Attachment 2: Grandfathered Small or Large Group Plan–***Not available for purchase with ACA Metallic plans***

Attachment 3: Non-Grandfathered Small or Large Group Plan– *Non-Metallic Plans* - ***Not available for purchase with ACA Metallic plans***

Section VIII. Ancillary Products

Group Term Life and AD&D ☐ YES ☐ NO

IMPORTANT: $15,000 Group Term Life and AD&D is required for groups with 2-50 eligible employees. Refer to proposal for separate Life and AD&D rates and benefits.

Amount of Coverage Selected: $ _____

Total PEPM Amount: $_____PEPM

Multiple of Salary	Class Description *(if applicable)*
☐ ____x annual salary up to $100,000	
☐ ____x annual salary up to $100,000	

Dependent Life ☐ **YES** ☐ **NO**

☐ Spouse $2,500/Children $1,250 ☐ Spouse $5,000/Children $2,500 ☐ Spouse $7,500/Children $3,750 ☐ Spouse $10,000/Children $5,000

IMPORTANT: Dependent life amount cannot be more than 50% of employee amount.

Group Term Life and AD&D benefits reduce 35% at age 65, 50% at age 70, and 70% at age 75. Employee must be actively at work on his/her effective date for Group Term Life and AD&D coverage to take effect. QualChoice Life and Health Insurance Company, Inc. is an independent company and operates separately from QCA Health Plan, Inc. QCLHIC is solely responsible for life insurance.$15,000 is mandatory for groups of 2-50 eligible employees on all medical benefit plans purchased.

Section IX. Ancillary Products *(cont'd)*

QualChoice Dental Benefits ☐ **YES** ☐ **NO**

- **PLAN ID No.**_____
- **Selected rates** (rates based on selected tier) ☐ 2 Tier Rates ☐ 3 Tier Rates ☐ 4 Tier Rates
- **Is dental coverage a medical match:** ☐ YES ☐ NO

Employer Dental Contribution

% of Employee Only	% Dependents	Employee Only	Employee & Child(ren)	Employee & Spouse	Employee & Family
		$	$	$	$

QualChoice Vision Benefits ☐ **YES** ☐ **NO**

- **PLAN ID No.** _____
- **Selected rates** (rates based on selected tier) ☐ 2 Tier Rates ☐ 3 Tier Rates ☐ 4 Tier Rates
- **Is vision coverage a medical match:** ☐ YES ☐ NO

Employer Vision Contribution

% of Employee Only	% Dependents	Employee Only	Employee & Child(ren)	Employee & Spouse	Employee & Family
		$	$	$	$

Section X. Authorization and Signatures

On behalf of the Group/Plan Sponsor, the undersigned agrees and attests the following:

- That the information entered on this *Product Selection & Sold Rate Form* is correct and complete.
- That submission of a *Product Selection & Sold Rate Form* containing a false statement, material misrepresentation, or omission constitutes insurance fraud and may result in termination of coverage. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- That coverage will **not** be effective prior to written approval from QualChoice and current coverage should **not** be cancelled prior to such approval.
- That the Group/Plan Sponsor agrees to the terms of the **Group Master Contract** and further agrees that this *Product Selection & Sold Rate Form* will be part of the agreement between the Group/Plan Sponsor and QualChoice.
- That consistent with the requirements of the Genetic Information Nondiscrimination Act of 2008, QualChoice does not use genetic information for underwriting purposes or any other purpose prohibited by applicable law. The undersigned acknowledges that as part of the application process QualChoice requested that it not be provided with any plan participant's family medical history or any plan participant's information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which the participant believes he/she may be at risk.
- That as the authorized representative of the Group/Plan Sponsor, you confirm receipt and accuracy of the conditions and assumptions made by QualChoice as set out in the fully insured proposal/quote. You further acknowledge that the final sold rates and benefits issued by QualChoice were based on these conditions and assumptions. You agree that if it is subsequently determined that any of these conditions and assumptions are incorrect, QualChoice has the option to immediately either retrospectively modify the rates and benefits provided or terminate the **Group Master Contract**.
- QualChoice disclosure regarding producer compensation: Brokers and agents (referred to collectively as "producers") may receive commissions and other compensation from us and these costs may be reflected in your premium or fee. Separately, you may have contracted with producers to provide services directly for your group and have to pay them a service fee. Since service fees are not a contingency of the purchase of health insurance such fees are not part of your premium, but may be included in your bill under Total Amount Due. In addition, we may pay bonuses pursuant to programs established to encourage the introduction of new products and provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonus expenses are not directly reflected in the premium rate but are included as part of general administrative expenses. At your request, a service fee to be paid to your producer/service agent will be added as an expense item where service fees apply.
- Producer compensation for large groups (100+) may be subject to disclosure on *Schedule A* of the *ERISA from 5500* for customers governed by ERISA. We provide *Schedule A* reports to our customers as required by applicable federal law. For specific information about the compensation payable with respect to your particular policy, please contact your producer.

Print Legal Name	Title
Signature **X**	Date (MM/DD/YYYY)
Approved by Broker/Agent **or** QualChoice Representative – PLEASE PRINT NAME	Title
Signature **X**	Date (MM/DD/YYYY)

POS and HMO plans underwritten by QCA Health Plan, Inc. | *PPO plans underwritten by QualChoice Life and Health Insurance Company, Inc.*
Group Term Life and AD&D and Dental Benefits underwritten by QualChoice Life and Health Insurance Company, Inc.
Vision Benefits underwritten by National Guardian Life Insurance Company. Administered by Superior Vision

Authorization for Automatic Payments — Group
ACH Debits

PLEASE PRINT

Section I. Group/Plan Sponsor Information		
Name of Group/Plan Sponsor	Name of Authorized Group Representative	Phone No.

Authorization for Automatic Payments

I authorize QualChoice to debit from our group bank account the amount necessary to pay the month- ly premium owed under our group's QualChoice contract. This authority will remain in effect until I, or another authorized group representative, notifies QualChoice or the bank/financial institution listed below, in writing to cancel it in such time (30 days) as to afford the bank a reasonable opportunity to act on the cancellation.

Section II: Bank/Financial Institution Information			
Name of Bank/Financial Institution	City	State	Zip Code

Please deduct our group's monthly premium from *(check one)*: ☐Checking ☐Savings

Account Number: _____ 9 Digit Routing Number: _____

Signature of Authorized Group Representative — Date (MM/DD/YYYY)

X

Section III: Account Holder Information

Print Name of Authorized Account Holder

Signature of Authorized Account Holder — Date (MM/DD/YYYY)

X

Section IV: Instructions

Mail:
QualChoice
ATTN: Finance Dept.
P.O.Box 25610
Little Rock, AR 72221

Fax: 501.707.6728

Email: qca_finance@qualchoice.com

If you have any questions, or if there is a change in your banking information, please call:
QualChoice Finance Department
501.228.7111 or 800.235.7111
Monday-Friday, 8:00 a.m. to 5:00 p.m., Central Time

Non-Grandfathered Small Group*: ACA Metallic Plans

Not available for purchase with non-Metallic plans

**2-50 eligible employees*

Name of Group/Plan Sponsor: _____

NOTE: If offering more than 2 options, this form may be copied as needed. Multiple plan options may be offered only if the same type--all POS or all PPO. Plans must be different metallic levels, for example: a Gold and a Silver plan, but not two Gold plans.

Point of Service (POS) Plan

Option 1	Option 1 Rates
Medical Plan ID _____	Enter the monthly premium below from the Medical Quote and attach *Underwriting Rate Table*. **Monthly Premium for Age Rated Groups: $**_____

Option 2	Option 2 Rates
Medical Plan ID _____	Enter the monthly premium below from the Medical Quote and attach *Underwriting Rate Table*. **Monthly Premium for Age Rated Groups: $**_____

Preferred Provider (PPO) Plan

Option 1	Option 1 Rates
Medical Plan ID _____	Enter the monthly premium below from the Medical Quote and attach *Underwriting Rate Table*. **Monthly Premium for Age Rated Groups: $**_____

Option 2	Option 2 Rates
Medical Plan ID _____	Enter the monthly premium below from the Medical Quote and attach *Underwriting Rate Table*. **Monthly Premium for Age Rated Groups: $**_____

Note: *Pediatric Dental was included in your original quote. The Affordable Care Act requires that to purchase a medical plan without pediatric dental, the group must provide a Qualified Health Plan Stand-Alone Pediatric Dental Plan to your employees.*

Grandfathered Small or Large Group

Not available for purchase with ACA Metallic plans

Name of Group/Plan Sponsor:_____

NOTE: If offering more than 2 options, this form may be copied as needed. Multiple plan options may be offered only if the same type--all POS or all PPO.

Point of Service (POS) Plan

Option 1	Option 2
☐ **Initial Selection** Medical Plan ID_____ Rx Plan_____ Example P2000A Example: $10/30/50/100	☐ **Initial Selection** Medical Plan ID_____ Rx Plan_____ Example P2000A Example: $10/30/50/100
☐ **Renewal** ☐ Renewal "As Is" ☐ Changing Plan to: Medical Plan ID_____ Rx Plan_____ Example P2000A Example: $10/30/50/100	☐ **Renewal** ☐ Renewal "As Is" ☐ Changing Plan to: Medical Plan ID_____ Rx Plan _____ Example P2000A Example: $10/30/50/100
Option 1 Rates	**Option 2 Rates**
Sold Premiums / Composite Rated Groups Employee Only $_____ Employee & Spouse $_____ Employee & Child(ren) $_____ Employee & Family $_____	**Sold Premiums / Composite Rated Groups** Employee Only $_____ Employee & Spouse $_____ Employee & Child(ren) $_____ Employee & Family $_____
Enter monthly premium below from the Medical Quote and attach *Underwriting Rate Table.* **Monthly Premium for Age Rated Groups: $**_____	Enter monthly premium below from the Medical Quote and attach *Underwriting Rate Table.* **Monthly Premium for Age Rated Groups: $**_____

Preferred Provider (PPO) Plan

Option 1	Option 2
☐ **Initial Selection** Medical Plan ID_____ Rx Plan_____ Example P2000A Example: $10/30/50/100	☐ **Initial Selection** Medical Plan ID_____ Rx Plan_____ Example P2000A Example: $10/30/50/100
☐ **Renewal** ☐ Renewal "As Is" ☐ Changing Plan to: Medical Plan ID_____ Rx Plan_____ Example P2000A Example: $10/30/50/100	☐ **Renewal** ☐ Renewal "As Is" ☐ Changing Plan to: Medical Plan ID_____ Rx Plan _____ Example P2000A Example: $10/30/50/100
Option 1 Rates	**Option 2 Rates**
Sold Premiums / Composite Rated Groups Employee Only $_____ Employee & Spouse $_____ Employee & Child(ren) $_____ Employee & Family $_____	**Sold Premiums / Composite Rated Groups** Employee Only $_____ Employee & Spouse $_____ Employee & Child(ren) $_____ Employee & Family $_____
Enter monthly premium below from the Medical Quote and attach *Underwriting Rate Table.* **Monthly Premium for Age Rated Groups: $**_____	Enter monthly premium below from the Medical Quote and attach *Underwriting Rate Table.* **Monthly Premium for Age Rated Groups: $**_____

Medical Optional Benefit Riders ***You must elect or reject each rider.*** *By electing any of the following benefit riders, premiums will be adjusted accordingly.*		Mandated Offer	Elect	Reject
POS and PPO Plans	**Mental Health and Substance Use Disorder** ***IMPORTANT:*** *Plan Sponsors with more than 50 eligible employees do not need to answer this question. You receive Mental Health and Substance Abuse Disorder benefits consistent with the Wellstone and Domenici Mental Health Parity and Addiction Equity Act of 2008.*	✓	☐	☐
	Temporomandibular Joint (TMJ) Disorder	✓	☐	☐
PPO Plans	**Hearing Aids and Hearing Instruments Benefit**	✓	☐	☐

Plan Selection ATTACHMENT 3

Non-Grandfathered Small or Large Group: Non-Metallic Plans

Not available for purchase with ACA Metallic plans

Name of Group/Plan Sponsor: _____

NOTE: If offering more than 2 options, this form may be copied as needed. Multiple plan options may be offered only if the same type--all POS or all PPO.

Point of Service (POS) Plan

Option 1	Option 2
☐ PreferredChoice ☐ FlexChoice ☐ RightChoice	☐ PreferredChoice ☐ FlexChoice ☐ RightChoice
Medical Plan ID_____ Rx Plan _____ Example P2000A Example: $10/30/50/100	Medical Plan ID_____ Rx Plan _____ Example P2000A Example: $10/30/50/100
Option 1 Rates – 10+ eligible employees	**Option 1 Rates – 10+ eligible employees**
Sold Premiums / Composite Rated Groups Employee Only $ _____ Employee & Spouse $ _____ Employee & Child(ren) $_____ Employee & Family $_____	**Sold Premiums / Composite Rated Groups** Employee Only $ _____ Employee & Spouse $ _____ Employee & Child(ren) $_____ Employee & Family $_____
Option 1 Rates – 2-9 eligible employees	**Option 2 Rates – 2-9 eligible employees**
Enter the monthly premium below from the Medical Quote and attach *Underwriting Rate Table.* **Monthly Premium for Age Rated Groups: $**_____	Enter the monthly premium below from the Medical Quote and attach *Underwriting Rate Table.* **Monthly Premium for Age Rated Groups: $**_____

Preferred Provider (PPO) Plan

Option 1	Option 2
☐ PPO Performance ☐ PPO Complete	☐ PPO Performance ☐ PPO Complete
Medical Plan ID_____ Rx Plan _____ Example P2000A Example: $10/30/50/100	Medical Plan ID_____ Rx Plan _____ Example P2000A Example: $10/30/50/100
Select a formulary: ☐ Enhanced ☐ Basic	**Select a formulary:** ☐ Enhanced ☐ Basic
Option 1 Rates – 10+ eligible employees	**Option 2 Rates – 10+ eligible employees**
Sold Premiums / Composite Rated Groups Employee Only $ _____ Employee & Spouse $ _____ Employee & Child(ren) $_____ Employee & Family $_____	**Sold Premiums / Composite Rated Groups** Employee Only $ _____ Employee & Spouse $ _____ Employee & Child(ren) $_____ Employee & Family $_____
Option 1 Rates – 2-9 eligible employees	**Option 2 Rates – 2-9 eligible employees**
Enter the monthly premium below from the Medical Quote and attach *Underwriting Rate Table.* **Monthly Premium for Age Rated Groups: $**_____	Enter the monthly premium below from the Medical Quote and attach *Underwriting Rate Table.* **Monthly Premium for Age Rated Groups: $**_____

Medical Optional Benefit Riders. You must elect **or** reject **each rider.** By electing any of the following benefit riders, premiums will be adjusted accordingly.		**Mandated Offer**	**Elect**	**Reject**
POS and **PPO Plans**	**Temporomandibular Joint (TMJ) Disorder**	✓	☐	☐
PPO Plans	**Hearing Aids and Hearing Instrument Benefits**	✓	☐	☐